



SHOULDER CLINICAL QUESTIONNAIRE

WHICH SHOULDER?  RIGHT  LEFT

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

\_\_\_\_\_  
\_\_\_\_\_

2. Please describe what specific complaints/symptoms have been most bothersome to you?

\_\_\_\_\_  
\_\_\_\_\_

3. How long have you had these complaints/symptoms? \_\_\_\_\_

4. Did these complaints/symptoms come on suddenly or gradually? \_\_\_\_\_

5. Are these symptoms the:  same  better  worse

6. Please check if you have any of the following:

- Neck pain on the same side
- Difficulty raising your arm
- Numbness, tingling, weakness, or pain radiating down the same arm

7. Have you ever had a prior shoulder injury (including dislocation)  yes  no

If yes, please describe: \_\_\_\_\_

8. Have you ever had surgery on this shoulder  yes  no

- Arthroscopic                      When and Where: \_\_\_\_\_
- Open Surgery                        When and Where: \_\_\_\_\_
- Shoulder Replacement            When and Where: \_\_\_\_\_

9. Have you ever had an Arthrogram on this shoulder?  yes  no

If yes, when and where? \_\_\_\_\_

